FORM E

Respiratory Care Professional

CHANGE OF MEDICAL DIRECTOR FORM

I hereby certify that _____, will be employed
Respiratory Care Professional Name

under my supervision as a Health Care Professional in Respiratory Care, effective

_____/_____/_____.

I hold an active license to practice medicine in the State of Georgia. My license

number is _____.

Please type or print: _____
Medical Director/Physician's Name

Signature: _____ Date:_____